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ABSTRACT

The medical model of reading diagnosis, which presumes something is wrong with the reader that can be diagnosed and remediated, needs to be reexamined. The ability to use writing as a communication tool, for example, must be considered as part of diagnosis if the purpose is to determine how literate someone is. Diagnostic tasks must also reflect the varied forms of real print, in real contexts, rather than offering short, contrived test tasks. Diagnosis, therefore, should be as broad in practice as reading must be by definition. One framework for such a diagnosis is labeled C. A. L. M., an acronym for Continuous Assessment of Language Model. This model perceives diagnosis as being a continuous and cumulative observation in a variety of settings, asking and restating questions. Several levels of the environment can be tapped as sources of data to generate initial diagnostic questions, including (1) the reader's microsystems, such as home, classroom, or day care center; (2) the reader's mesosystem, comprised of the interrelationships among the microsystems; and (3) the reader's exosystem, which embraces major social institutions that might affect the child's development of reading skills. Diagnostic procedures must sample as many of these systems as possible to create a valid, reliable, and complete picture of a reader's use of reading. (HOD)

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Re-examining and Re-thinking Reading Diagnosis

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Why re-examine and re-think reading diagnosis? We believe that the response to the question is simple, "Because it is time," but justification of such a simple response to be quite complex. We propose no new array of diagnostic instruments in this article, rather an opportunity for the reader to re-examine and re-think with us the role of diagnosis in reading instruction. The underlying rationale of nearly all current formal and informal diagnostic instruments including observational procedures and reporting techniques is medical, i.e. something is wrong with the reader and we need to find out what it is (diagnose) and try to fix it (remediate). A medical model gives students the subtle message that you learn how to read the way you are tested, one skill at a time. It also tells them that if you learn sub-skills, moving from one to another in a hierarchial fashion, you will become a fluent, competent reader.

It would be easy, however, to reject the medical model and provide no substitute one. Criticism is always easier than providing alternatives. We prefer to ask you, the reader, to move with us toward a framework for diagnosis derived from new learnings in both language acquisition and the study of the reading process. The explosion of research on how readers process and interact with print which has marked the past 10 years has resulted in a diverse body of new information about how children learn to read. To provide a way of organizing this information which crosses many disciplines, we will pose two important questions:

WHAT IS READING AND WHEN IS IT DONE WELL?

HOW DO WE ASSIST READERS WHO DO NOT LEARN TO READ WELL?

(1) What is reading and when is it done well?

Our re-examination of diagnosis begins with a look at a definition of reading which departs from the commonly accepted, skills-oriented one and focuses on reading as a literacy act and tool. We believe that reading is a literacy tool which enables the reader to receive ideas, experiences, feelings, and concepts. It is an activity which permits one to gain vast knowledge. When reading, we can live and travel vicariously and become acquainted with people and events of the past which have helped to shape our present world. Reading creates for us mental maps of events so that we gain ideas transmitted from the mind and soul of one, the author, to the mind and soul of another, the reader. Diagnosis using a medical model is limited and it rarely assesses reading when it is defined in this broad sense.

A broader definition of reading includes the reading-writing connection and school literacy vs. adult literacy. Levine (1982) urges us to add writing to our definition of literacy. He stated:

> Writing, in all but its most rudimentary forms, is omitted from existing conceptions and operationalizations of functional literacy. Yet it is, on the whole, writing competencies that are capable of initiating change. Writing conveys and records innovation, dissent, and criticism; above all, it can give access to political mechanisms and the political process generally, where many of the possibilities for personal and social transformation lie. (p. 262)

The ability to use writing as a communication tool must be considered as part of reading diagnosis if we are to truly determine how literate someone is.

Levine also insists we abandon the equivalence we have given to school literacy and adult literacy. He believes there are "massive differences between school literacy, which largely consists of academic exercises imposed on pupils as a curricular end in itself, and adult literacy, whose instrumental character naturally derives from its capacity to serve adult needs and projects" (p. 262). In conversation, Yetta Goodman referred to the term "school reading skills" as those skills only useful to children for proving they can pass reading tests in school as evidence of the ability to read. In effect, when diagnosing reading (or writing) proficiency, context matters. If we truly want to determine how effectively a child can 'read', then diagnostic tasks must reflect the varied forms of real print, in real contexts, rather than short, contrived test tasks. Such an insistence on context in diagnostic practice must also be carried over to research on diagnosis, too. Is a remedial reader always a remedial reader? Why do high school students who are failing content area subjects only succeed in remedial reading settings? Are reading achievement scores truly useful indicators for older readers, beyond grades 7 or 8? These are but a few of the questions related to the pragmatic contexts in which reading occurs which researchers must begin to address.

As a final part of our search for information to help us answer the question, "What is reading and when is it done well?", we are obligated to return to earlier literature on the topic of reading diagnosis. Have we made any changes in our conceptualizations? For a benchmark we have selected a classic work by Wiener and Cromer (1967) which examined four interrelated issues which emerged from their

examination of the many definitions of reading found in the 1950's and 1960's. We re-state each issue from the Wiener and Cromer article and comment on its validity today.

Issue #1. Identification versus Comprehension.

There was a tendency when the article appeared in 1967 for definitions of reading to separate these two factors. An examination of definitions of reading found in the current research on reading literature of the 1980's reveals a merging of these two factors at the level of theory, largely because of the influence of psycholinguistic insights which began to receive wider dissemination after the publication of the Wiener and Cromer article. While there is a merging at the verbal level in some reading diagnosis and methods texts, in clinical practice the merging appears much less evident. We can only conclude that few changes have been made in diagnostic practices which persuade us that reading educators truly understand or accept the possibility that identification and comprehension are interrelated. In fact, at the practicing diagnostic level, psycholinguistic insights have changed day-to-day testing procedures very little. Recent confirmation of our conclusion can be found in the work of Rogers, Merlin, Brittian, Palmatier, and Terrell (1983). They studied current practices in diagnostic practica, instruments used for diagnosis, remedial activities, and evaluation procedures. The list they generated of test instruments and techniques used in diagnosis is little changed from those widely used in the 1950's and 1960's.

Issue #2. Acquisition Versus Accomplished Reading

Weiner and Cromer also found a failure to distinguish between the acquisition of reading and accomplished or fluent reading in definition of reading. They wrote:

> The failure to distinguish between acquisition and accomplished reading in definitions partially accounts for the confusion about the relationship between identification and comprehension. In the acquisition of reading skills, identification may be a necessary antecedent to comprehension. (p.57)

They also stated that while identification might be necessary in the beginning stages of acquisition, it probably was not relevant for fluent or accomplished reading. Thus, "the final product of readin need not include components that went into its acquisition" (p.58). While the terminology may have changed with the infusion (or intrusion) of recent thinking from cognitive psychology and psycholinguistics, the debate continues today under the guise of sub-skill vs. holistic acquisition of reading and swirls around the validity of terms such as automaticity and mediated vs. immediate comprehension. Is this progress or merely a raising of the issue to a higher level of confusion and schism with resolution even more difficult in spite of new knowledge? Frankly, we're not certain.

Issue #3. Relative Versus Absolute Criteria

Weiner and Cromer found much ambiguity in the literature about what constitutes good and poor reading. Poor reading, they noted, appeared to be used "as a generic term, apparently without the recognition that different investigators may be talking about very

different forms of behavior" (p.59). Further they imply that determining whether a child is a good or poor reader is linked closely to an IQ test score for the child. The reading expectancy formula (Bond and Tinker, 1967) which relies on intelligence test scores was a widely used index in 1967. Some recent texts (Brown, 1982; Gillet & Temple, 1982) have abandoned these expectancy formulas. Others (e.g. Rude & Oehlkers, 1984; Wilson, 1981) include it, but with innumerable and carefully stated limitations; while some authors (e.g. Dechant, 1981) discuss the use of formulas at great length and issue only minor cautions on their use.

Issue #4. Reading Versus Language Skills.

Of all the issues raised by Weiner and Cromer in 1967, this one appears to have experienced the greatest change. They noted that, "failure to be explicit about the relationship between reading and previously acquired auditory language often leads to ambiguities as to whether a particular difficulty is a reading problem, language problem or both" (p.59). Recent research and writing has helped define that relationship as well as clarify the issue of writing and its relationship to learning to read. The work of Clay (1979); Ferreiro and Teberosky (1982); Goodman (1980); Graves (1983); Holdaway (1979); Levine (1982), Lindfors (1980); Smith (1982); Veatch (1978), to name a few, presents ample evidence of movement toward a language-based definition of reading. The diversity of disciplines represented by these writers further strengthens our opinion that here has been considerable change by leading experts, at least at the definition level. At the practitioner's level of remedial reading and diagnosis, we see much less change in either tests, materials, or procedures (see Rogers, et.al., cited earlier).

What does this all mean?

Recent learnings about language acquisition and the reading process mandate we begin our re-examination of reading diagnosis with a re-defining of what is reading and when is it done well. Reading is a literacy act and a tool which allows readers to use it as a means of receiving ideas, experiences, feelings and concepts. Diagnostic procedures must measure the effectiveness and the degree to which a reader uses reading for all these diverse functions; in other words, each student's strengths and needs in literacy skills. Diagnosis, therefore, is as broad in practice as reading must be by definition.

(2) How do we assist readers who do not learn to read well?

Our definition of reading requires diagnostic procedures to take on broader parameters, too. When we ask, "What is reading and when is it done well?", we must look at individual readers in many settings and observe strengths, not weaknesses. Observing them in a variety of reading contexts as whole individuals must dominate the diagnostic process. Observing readers for periods of time in a variety of situations provides varied data about both their reading and other language behaviors. The collection of data is involved, cumulative, ongoing, and time consuming. It is closer to the work of an anthropologist as ethnographer or a detective, than it is to that of a physician (Gilmore & Glatthorn, 1982; Green & Wallat, 1981). A thorough diagnosis should result in a picture of each reader's reading and language performance. The framework we propose for such a diagnosis is labeled C.A.L.M, an acronym for Continuous Assessment of

Language Model. It provides a paradigm for collecting information to form tentative hypotheses about a reader's abilities and needs. The diagnostic process becomes cumulative in two ways, in multiple settings and in multiple observation times. Diagnosis is, therefore,

-continuous observation in a variety of settings.

-conducted over time.

-asking questions.

-restating questions.

-cumulative and ongoing.

Initially, diagnostic questions are general, but as data are collected they become specific and narrow. These then become restated questions and broad again, as further observation are collected and recorded. Tentative hypotheses derived from observations in one setting are tested in multiple settings to determine their validity. Slowly, carefully, the diagnostic picture becomes clearer as evidence of performance and competence emerge from the data.

Other tools of a diagnostician who adopts the C.A.L.M. framework, in addition to observation, may include those associated with and adapted from the traditional case study approach (Harris & Sipay, 1980); unobtrusive measures such as physical evidence of the uses of reading a reader makes; ethnographic interviews (Spradley, 1979); and, school records. The data pool grows and grows over time, limited only by the constraints placed on the diagnostician by the amount of time and settings available. The greater the amount of time and the larger the number of settings the higher the reliability and validity of the diagnostic process.

One useful way of describing the "ideal" diagnostic process would be to employ descriptive terms for the successive levels of the educational environment adapted from Brim and used by Bronfenbrenner (1976). Each of these successive levels of the environment can be tapped as sources of data to generate initial diagnostic questions. Briefly, diagnostic questions formulated from that data collected as follows:

Level 1 - micro-systems of the reader which include discrete settings such as home, classroom, day care center. Bronfenbrenner defines a setting as a place where readers engage in the act of reading in a role (student, brother, sister, etc.). A small sample of initial diagnostic questions which can be asked in these settings might be:

"How much reading is done?"

"Is there extra help being given?"

"When does reading take place?"

"How much time is devoted to formal reading instruction?"

"What is the reader's basal reading level?"

"Does the reader initiate leisure reading times?"

"Is the reader viewed as a 'problem' in school?"

"Are parents aware of the reader's difficulty in school?"

"Are there signs of an established attitude about reading?"

Level 2 - meso-system of the reader is comprised of the inter-relationships among the microsystems. Any interactions which can be discovered which demonstrate a relationship between reading done in one setting (e.g., school) and in another setting (e.g.,

family or peer group) are noted and recorded. Some initial diagnostic questions which might be asked while looking for these interactions are:

"Are there any connections between reading done at school and reading done outside of school?"

"Is there a similar perception of the reader's competence across settings?"

"Is the child a poor reader in any place other than school?"

"Are there compensating factors evident outside of school?"

Level 3 - exo-system of the reader embraces the major institutions of society which might affect the child's development of reading skills. The role the community assigns to the school, media attitudes toward education, governmental requirements, in other words, whatever resources are made available to schools and requirements made of these same schools. These forces ultimately shape both the nature and quality of reading instruction. While this level appears too complex and loaded with political overtones to be part of the diagnostic process, it cannot be ignored. The simple reality of what kinds of help will be available to children identified and diagnosed a needing assistance in learning to read must be considered during the diagnostic process. If schools cannot, or will not, provide quality assistance for children with reading problems, diagnosis is useless. Questions related to diagnosis at the exo-system level might include:

"Is there a commitment by the school to assist children with reading problems?"

"What school district policies and programs exist which address the issue of remedial instruction?"

"Are school facilities, such as libraries, rich in resources?"

Each of the above systems impinges on an individual's successful acquisition and use of reading. Diagnostic procedures must sample as many systems as possible to create a valid, reliable, and complete picture of a reader's use of reading as a communication tool. Once the best possible picture is created, then decisions can be made by diagnosticians, parents, and the reader. These decisions form the basis for the ultimate goal of any diagnosis--directing change in pedagogical practices which result in improved use of reading as a communication tool.

WHAT HAVE WE SAID?

The nature of the diagnosis which follows the Continuous Assessment of Language Model (C.A.L.M.) framework offers diagnosticians a legitimate way to incorporate varied aspects and experiences of students' lives into the case report. It, in essence, provides a means for developing a broader picture of looking at the student holistically. In this article we presented no new array of diagnostic instruments, rather an opportunity for you, the reader, to re-examine and re-think the role diagnosis plays in reading and language education. For us, diagnosis requires continuous gathering of information about the student reader and writer. The collection of data about the student guides one to raise questions for seeking new

information. The new data about each student then guides the diagnostician in restating the initial questions and beginning the process again. This process--the broader view of diagnosis through C.A.L.M--will open doors for students to learn to read to learn.

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